# RIte Share Co-Pay Only

# New Group Enrollment Form

**Please note that completing this form is not necessary if you currently have a Rhode Island Medical Assistance number.**

| | | | |
|---|---|---|---|
| **Group Name** | | | |
| **Group Tax ID Number** | **Group** | | |
| **Office Address** | **Street** | | **Suite/Room** |
| | **City** | **State** | **ZIP** |
| | **Contact Name** | **Title** | **Phone** |
| **Pay To: Address** | **Street** | | **Suite/Room** |
| | **City** | **State** | **ZIP** |
| | **Contact Name** | **Title** | **Phone** |
| **Mail To: Address** | **Street** | | **Suite/Room** |
| | **City** | **State** | **ZIP** |
| | **Contact Name** | **Title** | **Phone** |

| | | | | |
|---|---|---|---|---|
| **Group Member's Information*** | **Last Name** | **First Name** | **Middle Initial** | **Title** |
| **Group Member's Signature:** | _____ **Sign** | | | **Date** |
| **Group Member's Information*** | **Last Name** | **First Name** | **Middle Initial** | **Title** |
| **Group Member's Signature:** | _____ **Sign** | | | **Date** |

**Groups, establishing a practice, please include:**

- **W-9, signed**
- **Provider Agreement, signed**
- **Addendum I, signed**
- **Electronic Funds Transfer (EFT) form**
- **A copy of the NPI letter from CMS that contains the group's NPI and Taxonomy number**

*** Please enclose a copy of each member's license and NPI letter from CMS**